

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2526

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02542

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the date and hour when the certificate was signed. File Pages 1, 2, and 3 with the registrar prior to burial, cremation, or removal. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Market Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CARL	Middle MERRILL	Last BRITTINGHAM
4. DATE OF DEATH	Month February	Day 7	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Dec. 28, 1892	9. AGE (in years less birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant	10b. KIND OF BUSINESS OR INDUSTRY Service Station	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Lloyd Brittingham	14. MOTHER'S MAIDEN NAME Iva Merrill		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes	16. SOCIAL SECURITY NO. 227-24-0437	17. INFORMANT John L. Brittingham, New Church, Va.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 229X DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO cause lost. (c)		<i>Intestinal obstruction</i> 304 days <i>Abdominal tumor. SK</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Brittingham Cemetery
20f. (City or town) Rural-New Church	(County) Virginia	(State) Virginia	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>N. E. Sartorius, Sr.</i>	DATE SIGNED <i>2/2/61</i>		
EXAMINER'S NAME (Type) N. E. SARTORIUS, SR.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 9, '61	22c. NAME OF CEMETERY OR CREMATORIUM Brittingham Cemetery	22d. LOCATION (City, town, or county) Rural-New Church, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry H. Labore</i>	ADDRESS Pocomoke City, Md.	24a. REC'D BY REGISTRAR FEB 14 1961	24b. REGISTRAR'S SIGNATURE Arthur S. Trahan

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2527

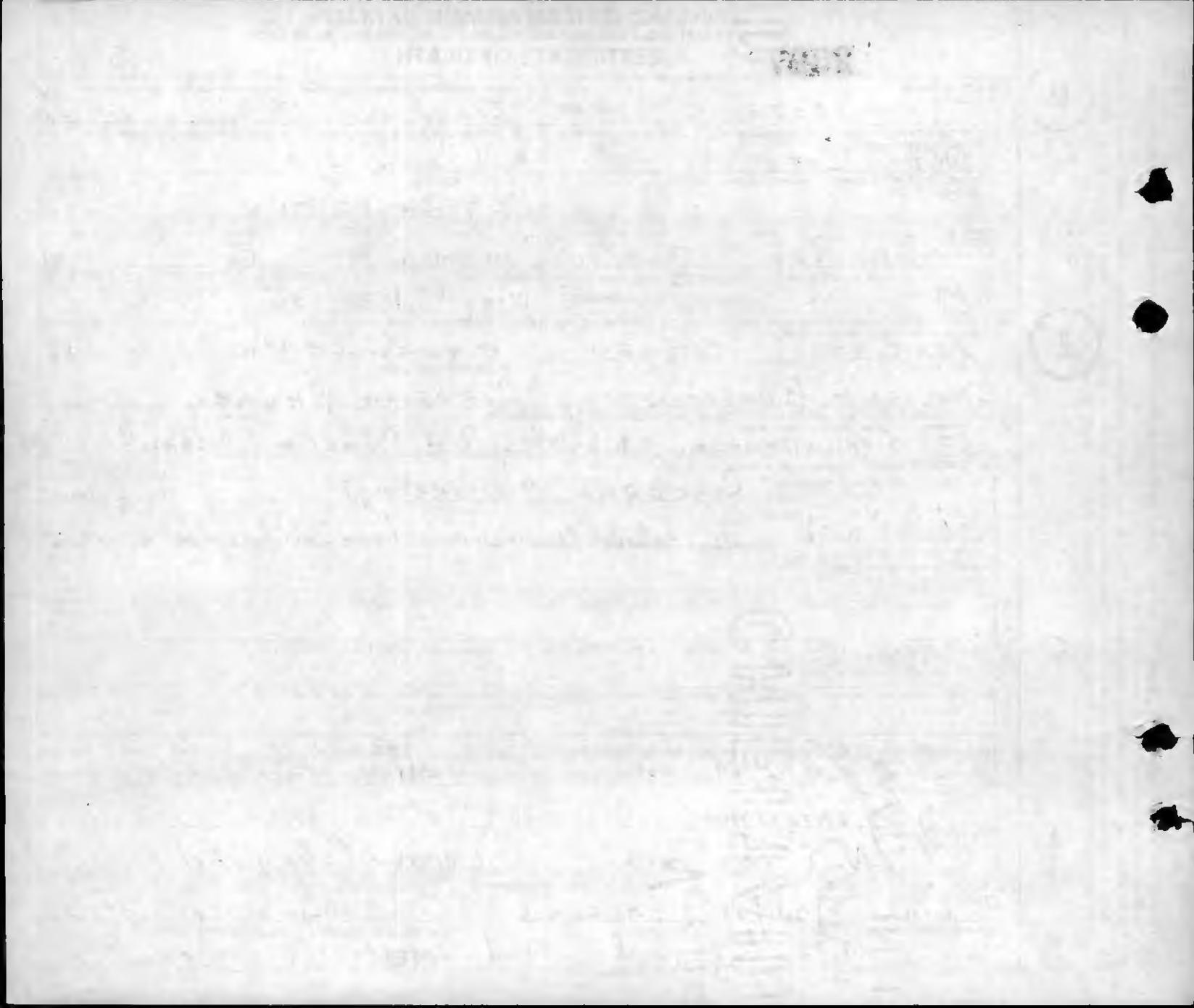
CERTIFICATE OF DEATH

12503

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
WORCESTER MARYLAND		MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X OCEAN CITY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1709 BALTO. AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
DR. Roy		ALFRED	BUHRMAN
4. DATE OF DEATH		Month	Day
FEB. 19		Year	1961
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
M		W	
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR IF UNDER 24 HRS.
MAY 19, 1880		80 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DENTIST		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) MAYERSVILLE MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES A. BUHRMAN		14. MOTHER'S MAIDEN NAME COROGLIA RAYMER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES SPANISH AMERICAN		16. SOCIAL SECURITY NO. NO MRS. R.A. BUHRMAN, OCEAN CITY MD.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 1/2 hour	
Cerebral Hemorrhage			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 452			
DUE TO (b) arterio sclerotic Cerebro vascular disease cold hemiplegia		6 years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____ P.M., from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE R. Thomas		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) R. Thomas		22d. ADDRESS Ocean City, MD	
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/21/61	
23c. NAME OF CEMETERY OR CREMATORIAL PARSONS		23d. LOCATION (City, town, or county) SALISBURY	
24. FUNERAL DIRECTOR'S SIGNATURE Anna R. Burbage Berlin Md.		25a. REC'D BY REGISTRAR FEB 23 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE R. R. 2 Tidewater	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2528

Reg. Dist. No. 1125-A

FOR STATE
HEALTH DEPT.

If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PNA3. Page 3 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gardetree (Rural)</i>	c. LENGTH OF STAY IN 1b <i>years</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i></i>	e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gardetree (Rural)</i>			
3. NAME OF DECEASED (Type or print) <i>Peter</i>	4. STREET ADDRESS <i>R 29</i>	d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		

5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Oct 1909 57</i>	9. AGE (In years from birthday) yrs. <i>57</i>	10. IF UNDER 1 YEAR Months Days Hours Min. <i></i>
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10a. USUAL OCCUPATION (Give kind of work done During most of working life, even if retired) <i>Debber in kitchen, chicken keeper</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Chicken keeper</i>	11. BIRTHPLACE (State or foreign country) <i>Wa</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>Peter Connor</i>	14. MOTHER'S MAIDEN NAME <i>Bessie Handy</i>	Address <i>Gardetree Md</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yer. no. or unknown) <i>Not</i>	16. SOCIAL SECURITY NO. <i>222-14-7685</i>	17. INFORMANT <i>John Handy</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxiation</i>	19. INTERVAL BETWEEN ONSET AND DEATH <i>17 days</i>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <i></i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Head buried in pillow (face down)</i>	20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i></i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Albion</i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <i>Natural causes</i>	22. ACTUAL SIGNATURE <i>N.F. Sartorius Jr.</i>	23. EXAMINER'S NAME (Type) <i>N.F. Sartorius Jr. MD</i>	24. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i></i>
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25. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>	26. DATE THEREOF <i>Feb 1961</i>	27. NAME OF CEMETERY OR CREMATORIUM <i>Boalsprings Cemetery</i>	28. LOCATION (City, town, or county) <i>Gardetree</i>
29. CEMETERY ADDRESS <i>Mayo C. Snow Hill, MD</i>	30. REC'D BY REGISTRAR DATE <i>Feb 6 '61</i>	31. REGISTRAR'S SIGNATURE <i>Arthur L. Knott</i>	

WISCONSIN STATE DEPARTMENT OF HIGHER EDUCATION
OFFICIAL EXAMINEE CERTIFICATION

EX-1

EX-1
EX-1

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EX-1

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EX-1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

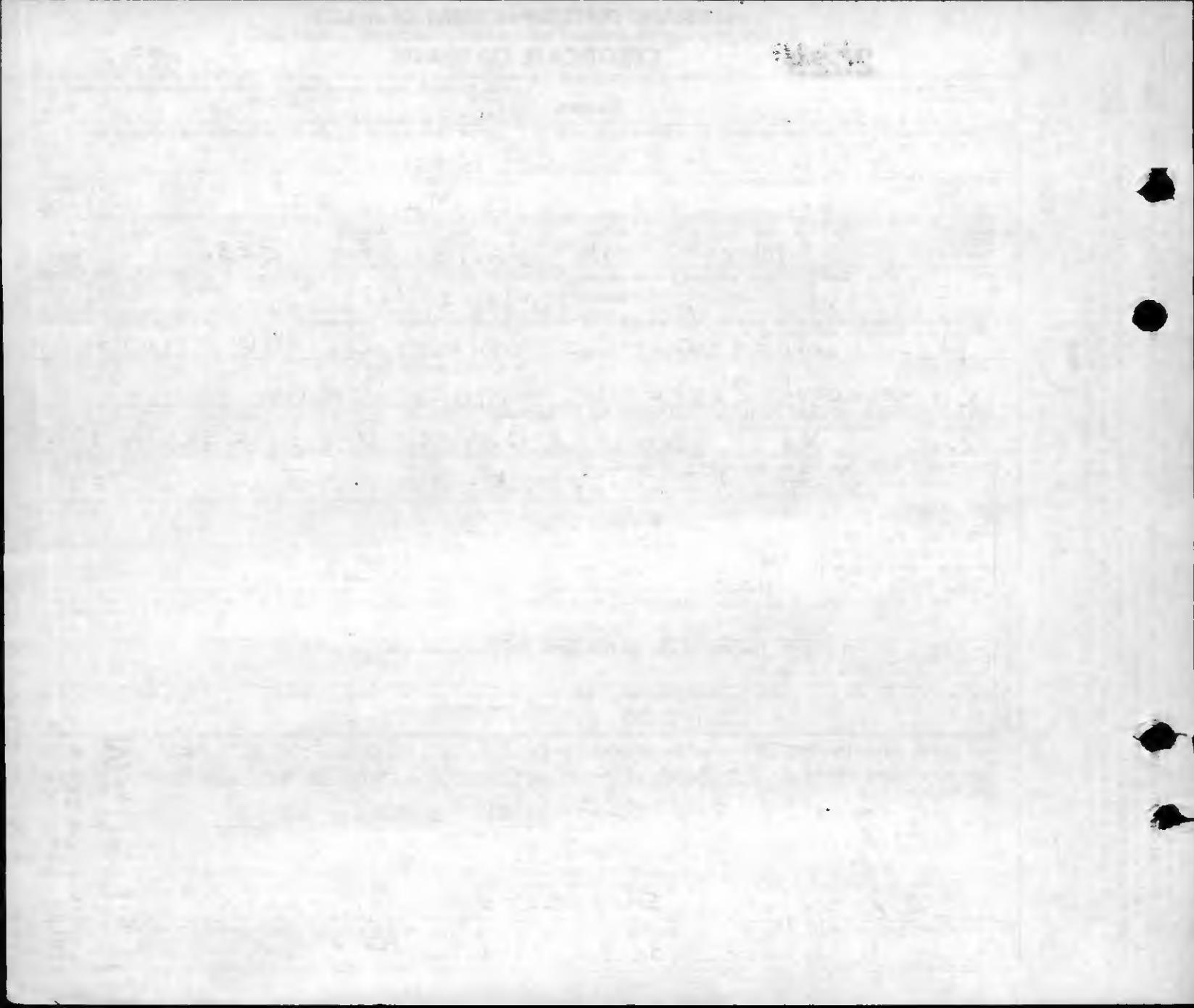
2529

Item 1-FilmG281 2-17-61 et

CERTIFICATE OF DEATH

02505

1. PLACE OF DEATH a. COUNTY WORCESTER		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		d. STREET ADDRESS 15. MAIN ST			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		First	Middle	Last	4. DATE OF DEATH 3-18-61	Month	Day	Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 2, 1879		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WELCHVILLE MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHARLES W. COOPER		14. MOTHER'S MAIDEN NAME MARY DENNIS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No			
17. INFORMANT J. BAYARD DAVIS		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Address BERLIN MD			
420.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) Hypertension		INTERVAL BETWEEN ONSET AND DEATH -? -					
		DUE TO (c) Cardiac Asthma - Angina		-? -					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) BERLIN		(County) 	(State) MD
21. I certify that (I) (this hospital) attended the deceased from 8-1 19 60 to 8-1 19 61 , that (I) (we) last saw the deceased alive on 1-28 19 61 , and that death occurred at 135 PM , from the causes and on the date stated above.								22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) CHIFFORD E. SCHOTT MD		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/5/61		23c. NAME OF CEMETERY OR CREMATORIAL EVERGREEN		23d. LOCATION (City, town, or county) BERLIN		(State) MD	
24. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage Berlin Md		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 15 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

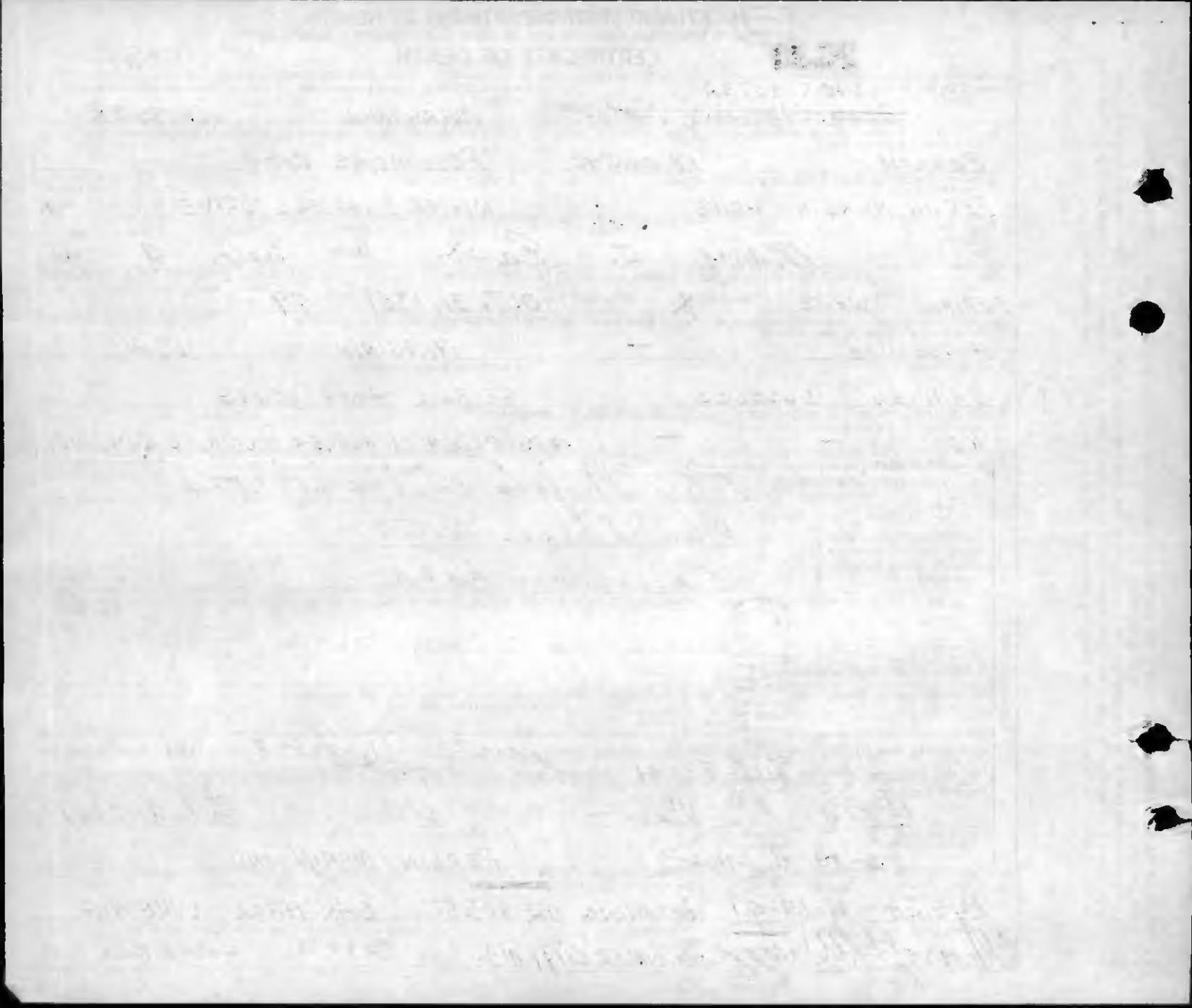
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2530

CERTIFICATE OF DEATH

02506

1. PLACE OF DEATH a. COUNTY	WORCESTER Berlin Nursing Home MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	MARYLAND		b. COUNTY	WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	BERLIN		c. LENGTH OF STAY IN 1b	18 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	POCOMOKE CITY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	BERLIN NURSING HOME		d. STREET ADDRESS	WINTER QUARTER'S DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Mary	Middle J.	Last East	4. DATE OF DEATH	Month Feby	Day 9	Year 1961	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
FEMALE	WHITE	OCT. 31, 1881	79 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		
HOUSEWIFE			—			VIRGINIA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			12. CITIZEN OF WHAT COUNTRY?		
SAMUEL WESSELLS			GEORGIE ANNA YOUNG			U.S.A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.			17. INFORMANT		
(If yes, give war or date of service)			—			MRS. ODEN W. HURLEY, Pocomoke City, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			Address					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			INTERVAL BETWEEN ONSET AND DEATH					
422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.			Chr. Myocarditis & acute attack					
(b) DUE TO			Chr. Bronchitis					
(c) DUE TO			Common cold					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 22-1961 to Feb 8-1961, that (II) (we) last saw the deceased alive on Feb 8-1961, and that death occurred at 7:15 AM, from the causes and on the date stated above.								
22a. SIGNATURE Chas. R. Law			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Feb. 9-1961			
22c. PHYSICIAN'S NAME (Type) CHAS. R. LAW			22d. ADDRESS BERLIN, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BYRIAH		23b. DATE THEREOF 2-12-61		23c. NAME OF CEMETERY DOWNING METHODIST		23d. LOCATION (City, town, or county) (State) OAK HALL, VIRGINIA		
24. FUNERAL DIRECTOR'S SIGNATURE Henry J. Watson		ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR FEB 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		
VR A15 (4) 15M 9/59								



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2531

CERTIFICATE OF DEATH

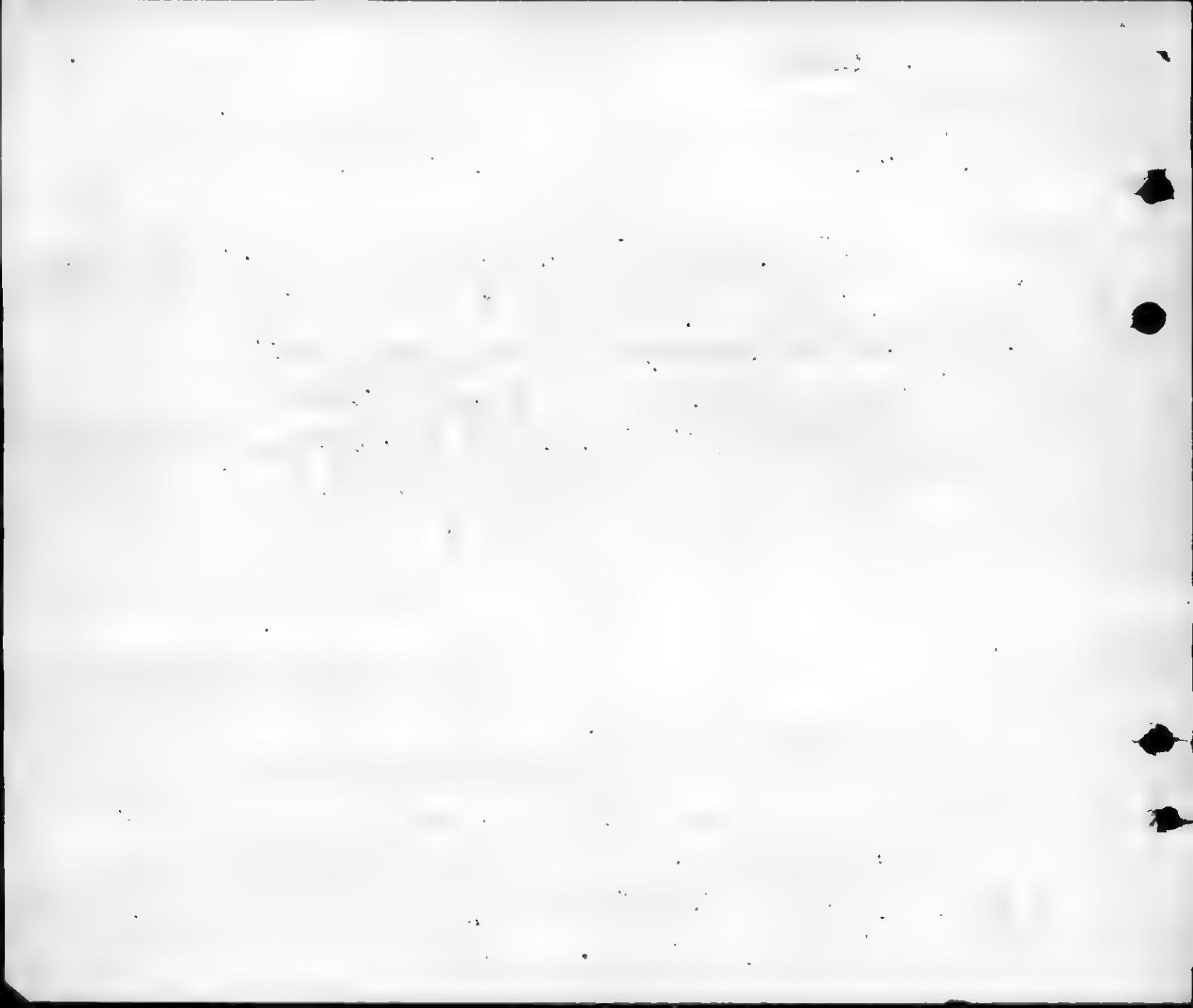
Reg. Dist. No.

125 17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
<i>Worcester</i>		a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY <i>Worcester</i>	
c. LENGTH OF STAY IN 1b <i>Snow Hill</i> <i>69 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Snow Hill</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	4. DATE OF DEATH Month <i>Feb</i> Day <i>7</i> Year <i>1961</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 25 1991</i>
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired)		10b. MIND OF BUSINESS OR INDUSTRY <i>Garage</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Snow Hill, MD</i>		<i>Snow Hill, MD</i>	
13. FATHER'S NAME <i>Frank Godfrey</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Marvel</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		16. SOCIAL SECURITY NO. <i>215-10-7632</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INFORMANT <i>Mrs. Edna C. Godfrey, Snow Hill, MD</i>	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420-9</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 min.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>AS HD.</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Acute myocardial infarct</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) <i>Carcinoma of Prostate</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>Snow Hill</i>	
21. I certify that I attended the deceased from <i>2/7</i> , 19 <i>61</i> , to <i>2/6</i> , 19 <i>61</i> , and that death occurred at <i>8 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>104 Bay Street</i> DATE SIGNED <i>2-7-61</i>	
ACTUAL SIGNATURE <i>David Rafat</i>		PHYSICIAN'S NAME (Type) <i>David Rafat, M. D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>2/7/61</i>	
22c. FUNERAL DIRECTOR'S SIGNATURE <i>May C. Dennis</i>		22d. NAME OF CEMETERY OR CREMATORIAL <i>Whitcoff Cemetery</i>	
23. ADDRESS <i>Snow Hill, MD</i>		24a. LOCATION (City, town, or county) <i>Snow Hill</i> (State) <i>MD</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>		24d. REC'D BY REGISTRAR DATE <i>FEB 9 '61</i>	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No 25-6

2532

1. PLACE OF DEATH
a. COUNTY

Worcester

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Pocomoke City

c. LENGTH OF STAY IN 1b

5 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)

a. STATE Maryland

b. COUNTY Worcester

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

4. Pocomoke City

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

Helen

Middle

Johnson

Last

DATE
OF
DEATH

Feb.

Month

3

Day
Year
1961

5. SEX

6. COLOR OR RACE

Female Negro

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

Mar. 13, 1912

9. AGE (In years
last birthday)

48 yrs.

10. USUAL OCCUPATION (Give kind of work done)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Laborer

Factory

Maryland

U.S.A.

13. FATHER'S NAME

William Waters

14. MOTHER'S MAIDEN NAME

Susie Brittingham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

No 1

Corbindell Johnson Pettit

St. Snow Hill, Md.

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

352 DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause lost.

(b) DUE TO
Initial cause, if any, giving rise to cause lost.

(c) DUE TO
Initial cause, if any, giving rise to cause lost.

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY
Month, Day, Year
Hour
a. m.
p. m.

20d. INJURY OCCURRED
While
at work Not while
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

2/4/61

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

2-9-61

22c. NAME OF CEMETERY OR CREMATORIUM

Baptist Cemetery

22d. LOCATION (City, town, or county)

Snow Hill, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Edgar Wharton - New Church, Va.

ADDRESS

24a. REC'D BY REGISTRAR

DATE 2/14/61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

1
2
3
4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

(125-13)

1. PLACE OF DEATH
a. COUNTY

Worcester

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Pocomoke City

c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

414 Cedar Street

3. NAME OF
DECEASED
(Type or print)

First
JOSHUA

Middle
T.

Last
MASON

4. SEX

6. COLOR OR RACE

Male

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE
OF
DEATH

Month
February

Day
18

Year
1961

10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired)

Foreman & Sawyer

10b. KIND OF BUSINESS OR INDUSTRY

Lumber

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Stephen T. Mason

14. MOTHER'S MAIDEN NAME

Ellen Hudson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)
(If yes, give war or date of service)

No

--

16. SOCIAL SECURITY NO.

213-05-2120A

17. INFORMANT

Address 414 Cedar St.
Mrs Elizabeth Mason, Pocomoke City, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Myocardial failure

INTERVAL BETWEEN
ONSET AND DEATH

14 hrs.

422
Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

Chronic Myocarditis

13 mos.

(c)

Arteriosclerosis, chronic, generalized, severe.

YES.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

(1) Hernia, rt. inguinal, to scrotum, severe. (2) Chronic Bronchitis, severe.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (1) (this hospital) attended the deceased from 72 Jan 1960 to 18 Feb 1961 that (1) (we) lost
saw the deceased alive on 18 Feb 1961 and that death occurred at 3:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

N. E. SARTORIUS, JR.

M.D. ATTENDING
PHYS

MED.
DIRECTOR STAFF
PHYS

22d. ADDRESS

Pocomoke City, Maryland

22b. DATE
SIGNED

2-19-61

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

Feb. 21, 1961 First Baptist

23c. NAME OF CEMETERY

23d. LOCATION (City, town, or county)

(State)

Pocomoke City, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Robert H. Watson

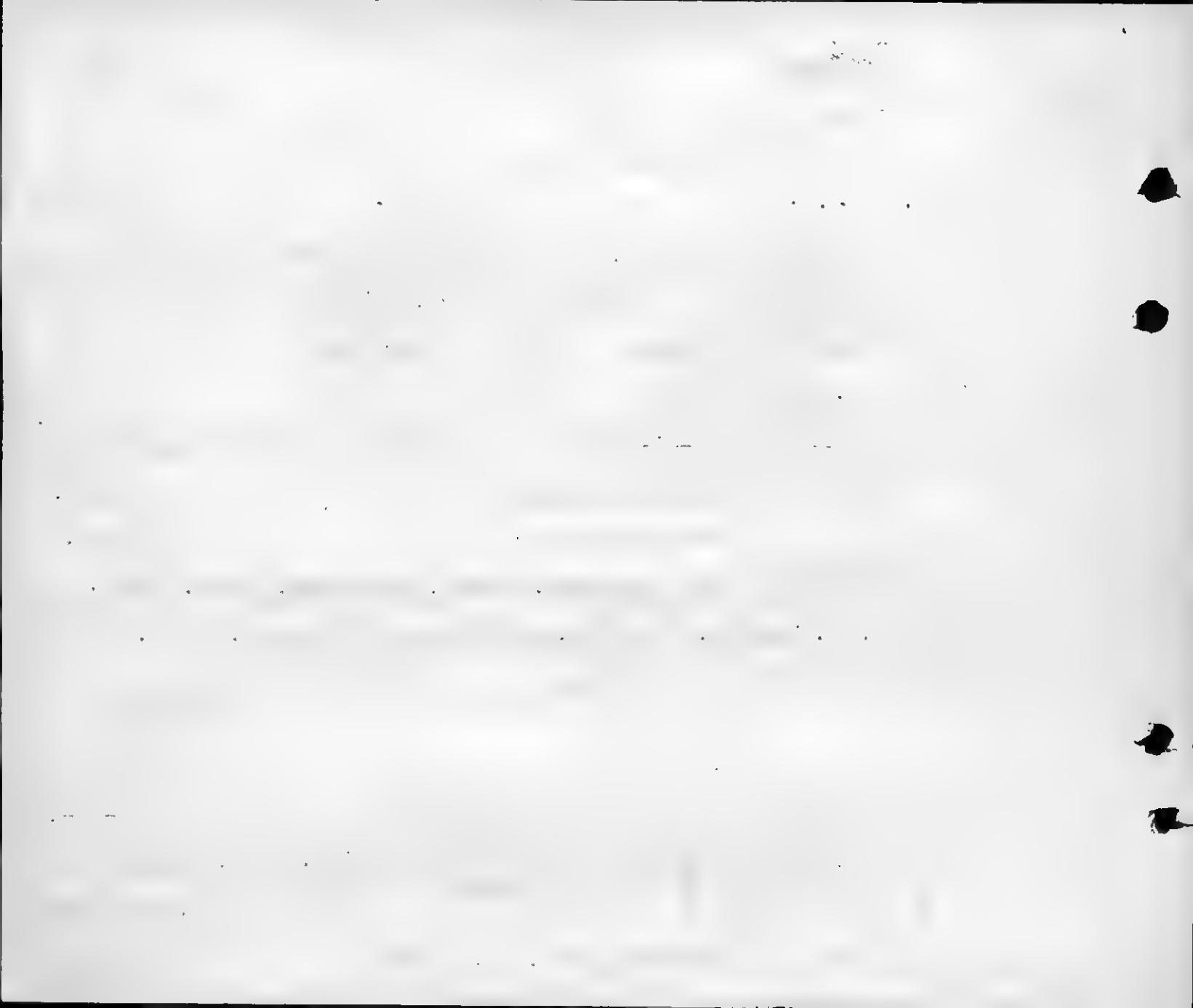
ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

FEB 23 '61

Calvin S. Kress



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours.

may be retained by the hospital or attending physician, and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2534

CERTIFICATE OF DEATH

112511

1. PLACE OF DEATH a. COUNTY WORCESTER		Item 8 Film 0282 07/7/61		a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE MARYLAND		b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		d. STREET ADDRESS LIBERTY TOWNS R. F. D.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First ALEX	Middle	Last NYAKAS	4. DATE OF DEATH FEB. 25 1961	Month FEB.	Day 25	Year 1961	
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1870 JAN. 31, 1871		9. AGE (In years lost birthday) 9	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	12. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OVYN FARM		11. BIRTHPLACE (State or foreign country) HUNGARY		12. CITIZEN OF WHAT COUNTRY? HUNGARY			
13. FATHER'S NAME ALEX NYAKAS				14. MOTHER'S MAIDEN NAME unknown.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO No		17. INFORMANT Mrs. JOSEPH KNAPP		Address BERLIN MD. RFD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)									
DUE TO Chronic myocarditis 3 Hypertension									
INTERVAL BETWEEN ONSET AND DEATH 2									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Jan. 1 to Feb. 25 1961		20f. (City or town) BERLIN		(County) MD.	(State) MD.
21. I certify that (I) (this hospital) attended the deceased from Jan. 1 to Feb. 25 1961 and that (I) (we) last saw the deceased alive on 2-25-61 and that death occurred on 2-25-61 from the causes and on the date stated above									
22a. SIGNATURE Clifford E. Schott		M.D. <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 2-25-61					
22c. PHYSICIAN'S NAME (Type) CLIFFORD E. SCHOTT MD		22d. ADDRESS BERLIN MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/28/61		23c. NAME OF CEMETERY OR CREMATORIAL RIVERSIDE		23d. LOCATION (City, town, or county) BERLIN MD.			
24. FUNERAL DIRECTOR'S SIGNATURE Anne A. Burbage Berlin MD		ADDRESS		25a. REC'D BY REGISTRAR MAR 1 '61		25b. REGISTRAR'S SIGNATURE Clifford E. Schott			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2535 112511

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		c. LENGTH OF STAY IN 1b <i>60 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>	
d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Nellie</i>		First <i>N</i>	Middle <i>B</i>
4. DATE OF DEATH <i>Feb 25 1961</i>		Month <i>Feb</i>	Day <i>25</i> Year <i>1961</i>
5. SEX <i>Female</i> COLOR OR RACE <i>white</i>		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>Oct 1 1882</i>
8. AGE (In years last birthday) <i>78 4/24</i>		9. IF UNDER 1 YEAR Months <i>78</i> Days <i>4</i> Hours <i>24</i>	10. IF UNDER 24 HRS
10a. US/JA OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Gardiner, MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>Gardiner, MD</i>	
13. FATHER'S NAME <i>Elijah Barnes</i>		14. MOTHER'S MAIDEN NAME <i>Mary G. Hudson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mr. Edward Barnes, Snow Hill, MD</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260</i>		INTERVAL BETWEEN ONSET AND DEATH <i>few hours</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>AS H D.</i>		years	
DUE TO (c) <i>Diabetes</i>		5 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Snow Hill</i> (County) <i>Worcester</i> (State) <i>MD</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 1960 to Feb 25 1961</i> , that (I) (we) last saw the deceased alive on <i>Feb 25 1961</i> , and that death occurred at <i>6 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>David Rafat MD</i>		22b. DATE SIGNED <i>2-25-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>DAVID RAFAT</i>		22d. ADDRESS <i>Snow Hill MD</i>	
23a. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) <i>DAVID Feb 25 1961</i>		23b. NAME OF CEMETERY OR CREMATORIUM <i>Whitewell Cemetery</i>	
23c. LOCATION (City, town or county) <i>Snow Hill</i> (State) <i>MD</i>		23d. LOCATION (City, town or county) <i>Snow Hill</i> (State) <i>MD</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Alley C. Dennis</i>		25a. REC'D BY REGISTRAR DATE <i>Feb 28 '61</i>	
ADDRESS <i>Snow Hill MD</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours by a physician or attending physician.

11. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2536 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film G281 2-27-61 et

Reg. Dist. No. 112513

1. PLACE OF DEATH a. COUNTY	Worcester		MARYLAND		2. USUAL RESIDENCE Where deceased lived. If institution, Residence before admission a. STATE	Md		b. COUNTY	Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Snow Hill, Maryland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Snow Hill, Md.										
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
3. SEX	4. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH	10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years including months and days) 38 yrs.	10c. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country)				
3	4 C	7 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10b. Housewife		Georgia			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME	Joseph Thomas		14. MOTHER'S MAIDEN NAME		Ellen Laasy Jones							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.		17. INVESTIGATOR		18. CAUSE OF DEATH (Enter only one cause per line) (a) (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
15	16		17		18 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				19 INTERVAL BETWEEN DEATH AND AUTOPSY Minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
The accused had been drinking												
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or Item 18.)											
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Snow Hill	(County) Worcester	(State) Md						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
22. ACTUAL SIGNATURE N. E. Sartorius												
23. EXAMINER'S NAME (Type) N. E. Sartorius												
24a. BURIAL, CREMATION OR REMOVAL (Specify)	24b. DATE THEREOF	24c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	24d. LOCATION (City, town or county) Snow Hill	24e. DATE	DATE SIGNED 2/18/61							
24a. REC'D BY REGISTRAR FEB 23 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Krause											
23. FUNERAL DIRECTOR'S SIGNATURE M. E. Dennis Snow Hill, Md.												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2537

CERTIFICATE OF DEATH

02514

1. PLACE OF DEATH a. COUNTY Worcester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Stockton		c. LENGTH OF STAY IN 1b 3 years		X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Stockton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 46		d. STREET ADDRESS Box 46		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JAMES	Middle STOCKLEY	Last WILSON	4. DATE OF DEATH February 15 1961	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1886	9. AGE (In years, last birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY General Painting		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William James Wilson		14. MOTHER'S MAIDEN NAME Florence Churn					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-14-3824		17. INFORMANT Mrs Marie C. Wilson, Stockton, Maryland		Address Box 46	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH few min.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>425-9</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b)		Cardiac Arrhythmia			
		DUE TO (c)		Cor Pulmonale		Years	
				(ASHD) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____		Sep. 1960 to Feb 1961, that (I) (we) last saw the deceased alive on Feb 14 1961, and that death occurred at 8 AM, from the causes and on the date stated above.					
22a. SIGNATURE <i>David Rafat</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) David Rafat, M.D.		22d. ADDRESS 104 Bay St., Snow Hill, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-18-61		23c. NAME OF CEMETERY OR CREMATORIUM Saint Paul's Cemetery		23d. LOCATION (City, town, or county) Druid Hill Park Balto. Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John C. Miller Inc. - 243-35 E. Oliver St.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 17 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

